Center Independent School District
Employee Request for Foreseeable Family and Medical Leave

Employee Name: _____ **Date:** _____

Campus/Department: _____

Position: _____

I request Family or Medical Leave for the following reasons:

- ☐ A. Birth of a son or daughter of the employee and to care for such son or daughter.
- ☐ B. Placement of a son or daughter with employee for adoption or foster care.
- ☐ C. To care for spouse, child, or parent with a serious health condition.*
- ☐ D. Serious health condition that prevents employee from performing his/her job functions.*

If answered "C" please complete the following relation information:

- ☐ Spouse
- ☐ Child
- ☐ Parent

Name: _____

Address: _____

Date on which you wish to start leave: _____

Date of anticipated return to work: _____

Are you requesting leave on a reduced or intermittent schedule? ☐ Yes ☐ No

If "Yes" give a schedule of when you will be unable to work:

_____

I hereby agree that, while I am on leave, I will continue to pay my share of health insurance premiums, unless I elect to discontinue coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse the district for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expires or that I am needed to care for my spouse/parent/child because he/she has a serious health condition on the date that my leave expires. I understand that I may not be permitted to resume my position with the District until I provide medical certification as appropriate.

_____ _____

Employee Signature **Date**

_____ _____

Administrator Signature **Date**

**An employee seeking leave because of reason "C" or "D" above must provide medical certification within 15 days or as soon as practicable.*

**An employee seeking to return to work after a leave because of his/her own illness ("D") must provide a medical certification of ability to perform job duties before being allowed to resume work.*

Completed forms & Medical Certification should be returned to Holly Mikesh in Human Resources.

Office Use Only

Date Received: _____ Date Certification Received: _____ Board Approved: _____